

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7303	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/20/2012
NAME OF PROVIDER OR SUPPLIER HARRIMAN CARE & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 240 HANNAH ROAD HARRIMAN, TN 37748		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments During complaint investigation number #30309, conducted on Septmber 19, 2012, at Harriman Care and Rehab Center, no deficiencies were cited in relation to the complaint under Chapter 1200-8-6, Standards for Nursing Homes.	N 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6599

FVMS11

If continuation sheet 1 of 1